DISABILITY/MEDICAL CARE COUNSELING STATEMENT

I, the undersigned have been counseled on this date of the following minimum requirement for obtaining medical treatment and/or applying for incapacitation pay :

1. I have been given a copy of CAL PAM 40-1(R), "Sick or Injured?"

2. I must promptly report to my unit when in need of medical care.

3. I cannot seek civilian medical or hospital care without written authorization from my unit, except for emergency life or death circumstances. Prior approval from OTAG and NGB is required for all non-emergency civilian medical care. **NOTE: IF I RECEIVE CIVILIAN TREATMENT WITHOUT FIRST OBTAINING APPROVAL FROM MY UNIT, AND/OR CAMP-MSB, OTAG, I MAY BE PERSONALLY LIABLE FOR THE MEDICAL BILLS.**

4. I must report, **without fail**, to all scheduled medical appointments, unless prohibited from traveling by another doctor. (A statement from the prohibiting doctor is required.) I must cooperate fully with personnel providing medical treatment. **FAILURE TO MEET A SCHEDULED APPOINTMENT CAN BE GROUNDS FOR TERMINATING DISABILITY PROCESSING AND/OR TERMINATION OF BENEFITS.**

5. **If I apply for Incapacitation Pay, I must be evaluated at least once every 30 days by a military physician.** A Disability Statement **(CA ARNG Form 40-6-2),** signed by the physician treating my injury, is required for each monthly period in which I am seeking incapacitation pay. I must furnish to my unit, after each of my medical appointments, the results of that appointment and the date of my next appointment.

6. I must also furnish my unit with a monthly Statement of Employment **(CA ARNG Fm 37-2E),** completed and signed by my employer, to include his/her name, address, telephone number, point of contact, dates worked, position held, hourly, weekly, or monthly rate of pay, **and a copy of a payroll check stub or payroll document, for the period I am requesting incapacitation pay,** showing hours worked, pay received, etc. If self-employed, I must provide a statement of earned income to include a copy of my last tax return forms filed with the IRS (all forms).

7. If I have been certified as "disabled" by a military physician, and have applied for incapacitation pay, I may **NOT** attend drill, AT or perform military duty during this period. **(NOTE: Only OTAG, CAMP-MSB may grant exceptions)**

8. I understand **I am not on active duty** while incapacitated. I will not accrue leave, nor receive active duty retirement points for the duration of this period, and will not receive ADT/IDT/AT pay with incapacitation benefits.

9. I authorize and request the Veteran's Administration, my civilian physician, the civilian hospital providing my medical care, or any other facility providing care to release any and all medical records, examinations, treatment records, and summaries to the Medical Services Branch, OTAG, and my unit of assignment.

10. **I understand that failure to fulfill the above requirement may disqualify me for receipt of incapacitation pay.**

11. I further understand the penalty for willfully making false statements or filing a false claim is a maximum fine of $10,000 or maximum imprisonment of 5 years or both (U.S. Code, Title 18, Section 287). I understand that claims adjusters at OTAG may contact my physician, employer, commander, etc., to obtain further information and/or validate my claim for incapacitation pay.

Date_____ Soldier's Name/Rank(printed)_____

Soldier's Signature_____ Counselor's Signature_____